RAPIDCARE
Patient Registration Form
(Please Print Clearly)

Reason for todays visit	Date / /

Patient Information			
Patient's last name: First Middle			Social Security Number: - -
Marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	Date of birth: / /	Age:	Sex: ☐M ☐F
Street address:	Home phone number:		Cell phone number:
City:	State:		Zip Code:
Name of person filling out form (if other than patient):			Relationship to patient:

Insurance Information		
Primary Insurance:	Date of birth: / /	Social Security Number: - -
Subscriber Name:	Relationship	Address
Secondary Insurance:	Date of Birth:	Social Security Number
Subscriber Name:	Relationship	Address

Guarantor DOB Social Security	Relationship:
May we leave a message concerning your treatment on your home/cell phone: ☐Yes ☐No	

In Case of Emergency		
Who to contact in case of emergency:	Relationship:	Phone number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rapidcare or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date

RAPIDCARE

Registration form page 2

E mail Address _____ No spam guaranteed. You can view parts of your chart and make changes to your medical history, update allergies, etc.

Name of your pharmacy _____ This is where we will send or call in your prescriptions

Please choose a secret password that we may ask you if we need to give you lab or X ray results over the phone

_____

Please sign here if you were given and have read the HIPPA forms attached to this document

_____ Date _____/_____/_____
(you may keep a copy of the HIPPA regulations)